BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **PATRICIA L. CLARKE, M.D.** Holder of License No. **26877** For the Practice of Allopathic Medicine In the State of Arizona.	Board Case No. MD-06-0667A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Letter of Reprimand & Probation)

The Arizona Medical Board ("Board") considered this matter at its public meeting on October 11, 2007. Patricia L. Clarke, M.D., ("Respondent") appeared before the Board with legal counsel Stephen Myers for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 26877 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-06-0667A after receiving a complaint regarding Respondent's care and treatment of a twenty-nine year-old male patient ("CW"). CW sought primary care from Respondent and saw her eight times in a six week period. CW had multiple concerns and complaints and Respondent ordered multiple tests. Respondent's medical records are difficult to read and follow and reflect diagnoses and treatments were made without clear evidence that the diagnosis existed or the treatment was needed.

4. CW presented to Respondent on April 27, 2006 for evaluation of his thyroid, hemorrhoids and heart palpitations. Respondent's review of systems and examination consists of several circled areas on her chart of complaints and areas examined, including abdominal pain,

diarrhea, possible melena, possible nausea and vomiting and heartburn. Respondent noted CW was severely anxious had an elevated uric acid. Respondent ordered lab work for CW, but did not order a serum uric acid and therefore, there is no laboratory result to confirm or refute that CW's serum uric acid was too high. Additionally, Respondent did not mention that CW had joint pain, swelling, or fluid removed from a joint even though theses are signs and symptoms of elevated uric acid. Respondent's assessment was hypothyroid, heart palpitations, hypertension and fatigue. Respondent placed CW on an event monitor and gave him Rocephin.

5. CW called Respondent's office on May 3, 2006 complaining of "flu-like symptoms" that would not go away. CW was very concerned about heart palpitations, complained of shortness of breath that would not go away, and asked to be monitored. Respondent documented the call and included that CW complained it hurt to have clothes on. Respondent noted CW was very, very, very anxious and was afraid he was going to die. Respondent ordered Pertussis serologies because of CW's earlier pertussis exposure. Respondent did not document the details of the pertussis and did not note in her review of symptoms any findings of cough or other respiratory symptoms typical of Pertussis. At this visit Respondent started CW on Biaxin for the Pertussis primarily because he presented with an infection that seemed bacterial rather than viral and he was very upset and concerned about it. Respondent was not absolutely certain CW did not have a viral infection.

6. On May 5, 2006 CW returned for another office visit complaining of feeling hot, dizzy, and anxious and was convinced there was something wrong with him. Respondent noted a PPD as negative, CW's blood glucose was 92 and his urine had a small amount of protein and bilirubin in it. Respondent's examination showed CW was orthostatic by blood pressure, but she noted no history of vomiting or diarrhea. CW's lab values (ordered May 3) were normal, however, Respondent diagnosed dehydration, fever (temp of 98), proteinuria and billirubinuria. Respondent ordered blood cultures and gave CW intravenous ("IV") fluids, but did not document the amount

given, the reason for giving it, or any history to suggest a reason for dehydration. Respondent noted concern over palpitations and commented "[d]oes this patient want to be sick?" From the labs drawn on this visit the abnormalities noted are an extremely high CRP at 94; EBV positivity showing old infection; a slight increase in PT at 11.9; some grass allergies and allergies to wheat and peanuts; low T4 and low T3 with high T3 uptake; slightly elevated IgG at 1647; positive test for Saccharomyces cerevisiae, IgA at 27.1; and IgG and IgA Pertussis test positivity. Respondent never re-checked or followed up on CW's extremely high CRP.

7. On May 8, 2006 CW complained of forceful heart beats and irregularity and of being very, very afraid of MI because of his family history. Respondent noted a water issue with CW noting increased volume intake of water and a family history of DM. Respondent noted her review of systems as negative and her exam noted CW was anxious, noncompliant and irritable. Respondent educated CW to increase fluids and questioned the possibility of diabetes insipidous and SIADH/Addision's among other things and diagnosed CP; SOB; dehydration (unchanged) and polyuria (new). Stool cultures this date were negative. CW returned for follow-up on May 9, 2006 and complained of feeling dizzy even though his water intake increased. Respondent gave CW three liters of NS IV over six hours. Respondent noted polyuria and a family history of diabetes, but normal blood glucose. CW also complained of SOB, CP, palpitations and tachycardia (that was being evaluated by event monitor and cardiology). Respondent noted CW was anxious, used some shorthand in her chart, and stated "many, many, many what ifs." Respondent diagnosed dehydration; polyuria; SOB; and CP, all unchanged. Respondent did not document anything to support that CW was dehydrated such as orthostasis, dry mucous membranes, tachycardia or abnormal electrolytes, yet Respondent gave CW three liters of NS over six hours.

8. Labs drawn on May 9, 2006 and reported May 11, 2006 showed normal serum sodium, potassium, calcium and osmolality. Respondent next saw CW in follow-up on May 22,

2006. CW completed previously prescribed antibiotics. Respondent noted a positive Pertussis IgA; an increase in uric acid and urine sodium; the abnormal labs from May 9, 2006; and complaints of tachycardia and palpitations and family history. Respondent noted a slight increase in glucose and PT and INR and the allergies. Respondent diagnosed Pertussis; allergies; Gout; and hypothyroid – all of which were stable. Respondent diagnosed Gout even though nothing in CW's medical record indicates he had Gout. Respondent planned spirometry and CXR. CW was going to look into going to the Mayo Clinic for an evaluation of his thyroid. Respondent ordered an ACTH and noted CW had lots of questions about inflammation.

9. CW returned to Respondent on June 2, 2006 indicating he wanted to discuss a blood draw. Respondent noted CW was full of anxiety, convinced something serious was wrong, and wanted to pursue an intense work-up. Respondent set up an ACTH with the lab on this same date; noted the cardiac work-up was in progress; and that CW has or would see a particular physician; and noted endocrine issues with elevated uric acid and urinary sodium, and a fasting blood glucose of 76. Respondent also noted some GI issues with food allergies and the positive test for Saccharomyces cerevisiae, IgA and IBS symptoms; and considered getting a GI consult after the ACTH was done. Respondent's review of symptoms was unremarkable and her exam notes an anxious patient who is non-compliant and irritable, but otherwise unremarkable. Respondent planned blood work and planned to order spirometry and CXR and to get dermatology, eye, dental, and cardiology evaluations. Respondent's diagnoses for the day included Gout, which was stable; hypothyroid, which was stable; allergies, which were stable; and hyperNA. The rest of Respondent's note is illegible. Respondent diagnosed Gout even though nothing in CW's medical record indicates he had Gout.

10. At a June 9, 2006 visit Respondent documented CW came in wanting detoxification and having lots of questions about his allergies. Respondent and CW discussed the ACTH order and Respondent noted CW was going to get the thyroid FMC scan results; that with

regard to gout, she would re-check it in a few months; that CW has diastolic hypertension (with something illegible written behind an arrow in her chart); and that she planned to have CW see cardiology on June 23. Respondent's review of systems circled fatigue and anxiety and her exam noted the same and that CW was a difficult patient who was anxious, non-compliant, and slightly irritable. Respondent completed a full examination and discussed food allergies and detoxification with CW and his wife and noted CW wanted "natural therapy;" further discussed with CW and his wife cardiology issues and noted anxiety around the possibilities of the abnormal results. Respondent's diagnoses list was gout unchanged, hypothyroid stable, allergies stable, and hyper NA in urine.

11. Respondent's charts are non-standard. For instance, in Respondent's charts a circled item indicates a "positive;" a strike-through line indicates a "negative;" an "X" indicates a pertinent "negative;" a circle or zero with a line through it means "none;" a triangle means "change;" a plus sign with "as" means "plus as noted;" and a question mark means the patient is non-compliant.

12. A physician is required to maintain adequate medical records. An adequate medical record means a legible record containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2). Respondent's records were inadequate because they were not fully legible and contained symbols and other marks that are not standard; they did not contain sufficient information to support her diagnoses or justify the treatment; and they did not provide sufficient information for another practitioner to assume continuity of the patient's care.

13. The standard of care requires a physician to evaluate a patient's complaints with a history and physical examination and appropriate lab and x-ray testing if indicated that is based on the history and physical examination findings and to place patients on indicated medications.

14. Respondent deviated from the standard of care because she did not appropriately evaluate CW's multiple medical issues and because she placed CW medications that were not indicated.

15. CW underwent unnecessary treatment for Gout when nothing in the record indicates he had Gout.

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records on a patient;") and A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient of the public").

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED:

1. Respondent is issued a Letter of Reprimand for failing to appropriately evaluate a patient with multiple medical issues and for failing to maintain adequate medical records.

2. Respondent is placed on probation for one year with the following terms and conditions:

a. Within one year Respondent shall obtain 20 hours of Board Staff pre-approved Category I Continuing Medical Education ("CME") in diagnosis and treatment of fluid and electrolyte abnormalities. The CME hours shall be in addition to the hours required for biennial renewal of medical license. Respondent shall provide Board Staff with satisfactory proof of attendance. The probation will terminate when Respondent supplies proof of course completion that is satisfactory to Board Staff.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that she has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 14th day of December, 2007.

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THE ARIZONA MEDICAL BOARD

By Amanda Diehl
AMANDA J. DIEHL, MPA, CPM
Deputy Executive Director

ORIGINAL of the foregoing filed this 14th day of December, 2007 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing
mailed by U.S. Mail this
14th day of December, 2007, to:

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Patricia Clarke, M.D.
Address of Record